“Enhancing Medication Reconciliation through Care Transitions”
June 2016
ACO Announcements

• Reminders:
  – ACO Notifications
  – PECOS-Maintain active enrollment
  – 2016 Patient Prospective Lists
  – Upcoming provider meetings:
    • Annual Wellness visit campaign
      – Regional Office manager meetings (July)
    • 9/13/2016 Primary Care Meeting
    • 11/10/2016 Primary and Surgery Sub Specialty
Agenda

• Importance and Process of Medication Reconciliation
• Communication to patients
• Innovative suggestions for Medication Reconciliation
• Q&A section
Why is Med Rec Important?

• More than 3.5 billion prescriptions are written annually in the U.S.
• Average Medicare beneficiary statistics:
  • See an average of 6.4 unique physicians per year
  • Have more than 20 prescriptions filled each year
  • About 19% have an inpatient stay
  • Those with multiple chronic conditions are 100 times more likely to have a preventable hospitalization
• Drug-related morbidity and mortality costs exceed $200 billion annually in the U.S., exceeding the amount spent on medications themselves
ACO Measure
CARE 3: Documentation of Current Medications in the Medical Record (NEW)

• Description:
  – Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

ACO Measure
CARE 3: Documentation of Current Medications in the Medical Record (NEW)

• What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient’s medical record must contain for each pre-filled office visit:

A list of all prescriptions, over-the-counter (OTC) products, herbals, vitamins, minerals, dietary (nutritional) supplements **AND** must contain the medication’s name, dosage, frequency and route of administration **OR** if the patient is not currently taking any medications.

THE IMPORTANCE OF MEDICATION RECONCILIATION

Greg Blette, PharmD
Clinical Pharmacy Consultant
Objectives

• Review the importance of medication reconciliation to both the patient as well as your practice
• Describe the overall process from start to finish
• Demonstrate ways in which to properly communicate this concept to the patient
• Analyze the relevance of this for your practice
• Identify ways in which to incorporate it into everyday work flow
• Discuss ways to improve your approach as well as your outcomes
PollEverywhere®

• Submit an answer to an audience question!
  • To use your browser:
    • Go to www.PollEv.com/gregblette725
    • Click the box next to your answer choice
  • To use your cell phone:
    • Text “GREGBLETTE725” to “37607”
    • Then text your answer choice

• Questions may also be answered in WebEx
  • Type your choice into the comment box
  • Won’t be directly counted towards the live poll
    • Also, won’t be anonymous if sent to everyone!
Question #1

Who is in the audience today?

• A. Prescribers (MD/DO, NP, PA, etc.)
• B. Provider Assistants (RN, LPN, MA)
• C. Office Personnel (Care Coordinator, Office Manager, etc.)
• D. CMP Associates
• E. Other!
Outline

• Background exploration and information
• What is medication reconciliation (definition)?
• Why it is so important?
• Reviewing medication list “sources”
• Best Possible Medication History (BPMH)
• Documenting the process and critical thinking
• High risk medications
• Case examples
RATIONALE AND BACKGROUND
-WHY MED REC?
Case Example #1 (Transitions)

73 year-old male at SAR was using their formulary drugs of dutasteride and tamsulosin, separately

- Prior to SAR admission from hospital discharge, it was documented that he was taking Jalyn (dutasteride 0.5 mg and tamsulosin hcl 0.4 mg) for BPH at home
  - On discharge from SAR, discharge reconciliation form listed Jalyn as home medication, and dutasteride and tamsulosin as inpatient medications – all three drugs were ordered
  - Patient was unaware of their similarity/duplication

-Patient readmitted in 12 days with severe hypotension-
**Disconnect of TOC with Med List & Discharge Summary**

Due to timing of discharge summary:
- Med List is not same in TOC and Discharge Summary and/or
- Discharge communication is too late for PCPs

**Med List & TOC & D/C Summary Workflow**

<table>
<thead>
<tr>
<th>D/C</th>
<th>D/C +24 hr</th>
<th>D/C +2 bus days</th>
<th>D/C +7 bus days</th>
<th>D/C +30 Days</th>
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<tbody>
<tr>
<td>Patient</td>
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<td></td>
<td>TOC</td>
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<td>F/U Appt</td>
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<td>POP Info</td>
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<td>MD</td>
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<td>D/C Med Rec &amp; D/C Med List</td>
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<tr>
<td>Nursing Unit</td>
<td>TOC 1</td>
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<td>TOC 2(3,4...)</td>
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<td>TOC Final in EDM</td>
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<td>PCP</td>
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<td>Cell Patient</td>
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<td>Receive D/C Summary</td>
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<td>Pull TOC</td>
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D/C Summary may not be available.
Why is Med Rec Important?

- IOM reported that medical errors, including medication errors, are one of the leading causes of morbidity and mortality.
- Prescribing errors due to inaccurate or missing patient medication histories and medication omissions may **not** be preventable even with Electronic Health Record (EHR) systems.
Why is Med Rec Important Cont’d?

• Financial implications for the institution including readmissions
• Patient care!

Words associated with pain and discomfort.
Med WRECK?!
“There was an important job to be done and Everybody was asked to do it. Anybody could have done it, but Nobody did it. Somebody got angry about that because it was Everybody’s job. Everybody thought Anybody could do it, but Nobody realized that Everybody wouldn’t do it. It ended up that Everybody blamed Somebody when actually Nobody did what Anybody could have done.”

~Anonymous
Be a Part of the Solution

The medication reconciliation crisis:

• We should do this not simply because there’s an acute need for someone to take ownership, i.e. “flavor of the month”

• Healthcare **teams** in provider offices are arguably the best suited for the critical thinking required

• Opportunity to demonstrate value in direct patient care, and with the care team and ability to manage a team around a care process

• Even with a single, unified EMR, we will still need to assess and address HOW a patient is utilizing their medications
Question #2

Who is responsible for medication reconciliation?

• A. Nurses
• B. Doctors only
• C. It’s not important
• D. Everyone!
Definition – Medication Reconciliation

Per Joint Commission:

• “The process of comparing the medications a patient is taking (and should be taking) with newly ordered medications”
  • In order to resolve discrepancies or potential problems

• It’s the most accurate and descriptive list of all medications including:
  • Name, dosage, frequency and route

• Therefore, the list can be appropriately used to provide correct medications for patients anywhere within the healthcare system
**What is it?**

- Medication reconciliation is a **process** by which ALL **current**:

  **Prescription**
  - Chronic medications
  - Appropriate acute Rx’s
  - May include devices or equipment

  **Over The Counter**
  - Those used daily, weekly, etc.
  - Infrequent but pertinent medications

  **Vitamin/Supplement**
  - Tablets, capsules, liquids, etc.
  - Dietary ingredients
  - Medical foods
  - Herbals

- Medication name, dose, *formulation*, route of administration, and frequency are collected and clearly stated
Question #3

What is medication reconciliation?

• A. Asking the patient if there have been any changes in their medications since their last appointment
• B. Relying on the physician to reconcile a patient’s medications
• C. A process by which ALL of a patient’s current prescription, OTC, and vitamins/supplements are evaluated to record their proper name, dose, formulation, route of administration, and frequency
• D. It’s not important enough to integrate into workflow
Question #4

From an Institute For Safe Medication Practices (ISMP) survey, which success factor was perceived as having the highest correlation with an effective medication reconciliation process?

• A. Reasonable expectations for “complete” history?
• B. Teamwork among disciplines?
• C. Medication history by a pharmacist?
• D. Universal communication amongst outpatient providers?
ISMP Survey Results

• Collaboration is key!
• The best practice medication reconciliation team is one that is multidisciplinary and -in all settings of care- will include physicians, mid-level providers, pharmacists, nurses, ancillary health care professionals and clerical staff.

<table>
<thead>
<tr>
<th>Success Factor</th>
<th>Rank %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teamwork among disciplines</td>
<td>57%</td>
</tr>
<tr>
<td>Clearly defined protocols</td>
<td>39%</td>
</tr>
<tr>
<td>Centralized history form/screen</td>
<td>32%</td>
</tr>
<tr>
<td>Awareness of the role of each contributor</td>
<td>24%</td>
</tr>
<tr>
<td>Reasonable expectations for “complete” history</td>
<td>23%</td>
</tr>
<tr>
<td>Easy communication with outpatient providers</td>
<td>15%</td>
</tr>
<tr>
<td>History collection by a pharmacist</td>
<td>10%</td>
</tr>
</tbody>
</table>
ISMP Survey – What is this team?

• Assist with the overall process including educating the patients on the importance of it and making certain that everything is entered and documented appropriately

Ancillary healthcare professionals

• Can be key to overall success. “All of the evidence for the effectiveness of medication reconciliation involves pharmacists’ interventions”

Pharmacist/Pharmacy Team

• Plays a crucial role in starting the process, gathering information, and utilizing critical thinking skills

Nursing

• Active role with managing the process and ensuring proper completion of medication reconciliation within a timely manner

Physician/Provider

Medication List Sources

• Healthcare providers should often gather medication history information from several different sources in order to confirm inclusion of current medications.

• Discrepancies will still exist!
  • Between what may be documented in these records and what the patient is actually using and how they are taking them.
  • Patient interview (or family members, caregivers, etc.) can be crucial.

• Takeaway message:
  • There is rarely a single source of truth upon which healthcare providers can rely.
  • Therefore, a best possible medication list must be generated.
# Reviewing medication list “sources”

<table>
<thead>
<tr>
<th>Source</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Pharmacy prescription refill information       | 1. Often only source for some medications, especially if patient is from outside own medical system  
2. Provides information about adherence        | 1. Expensive to obtain                                                       |
|                                                |                                                                            | 2. Difficult to integrate with other information sources                      |
| Outpatient electronic medical record medication list | 1. May be easy to obtain and integrate with CPOE, especially if integrated EMR | 1. Only accurate if maintained by outpatient providers                        |
|                                                |                                                                            | 2. Doesn’t work if patients are from practices that don’t use that EMR        |
| Medication data from Health Information Exchanges (e.g., a Regional Health Information Organization – RHIO) | 1. May allow access to data from a variety of healthcare systems  
2. Data may be in a coded form that’s relatively easy to use | 1. Few regions with a robust system in place as of yet  
2. May have issues with data quality  
3. Only as accurate as the sources it comes from |

Adapted from the MARQUIS Implementation Manual from Society of Hospital Medicine Sept. 15, 2011
## Reviewing medication list “sources”

<table>
<thead>
<tr>
<th>Source</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Patient personal health records medication list | 1. Empowers patients/caregivers to own list, which in the end may be the best solution  
2. In theory might work regardless of system from which the patient gets regular care | 1. Not widely used  
2. Not widely maintained by patients/caregivers  
3. Not widely integrated into outpatient EMRs and inpatient systems |
| Discharge medication list from recent hospitalization | 1. If from same hospital, easiest to access  
2. May be easy to integrate into CPOE  
3. At one point in time, was accurate (in theory) | 1. May be out of date  
2. Access limited to discharges from same hospital or hospital system |
| Patient/caregiver’s verbal report            | 1. May be easy to obtain if patient communicative or caregiver available  
2. Assesses patient/caregiver understanding | 1. May be very inaccurate or incomplete  
2. Not available in some cases (e.g., patient delirious, family not available) |
| Medication list on paper from patient/caregiver | 1. Easy to obtain (if available)  
2. A bridge to a long-term solution | 1. May be very inaccurate or incomplete  
2. Often not available |

Adapted from the MARQUIS Implementation Manual from Society of Hospital Medicine Sept. 15, 2011
This is our local Regional Health Information Exchange Organization (RHIO)

- Portal for a single access point for health-related information
- Facilitates the sharing of information amongst providers
- Link to all training videos:
  - [http://www.wnyhealthelink.com/PhysiciansandStaff/TrainingVideos](http://www.wnyhealthelink.com/PhysiciansandStaff/TrainingVideos)

- Prescription Refill History Query function may be most helpful for medication reconciliation
  - Layout/functions may be updated periodically
Prescription Refill History Query Video

Completing a Medication History Query

Reviewing medication list “sources”
BEST POSSIBLE MEDICATION HISTORY (BPMH)
Best Possible Medication History (BPMH)

• **Compiling the Best Possible Medication History**

  • The goal is to obtain complete information on the patient’s medication regimen, including:
    - Name of each medication
    - Formulation (i.e., extended release)
    - Dosage
    - Route
    - Frequency
    - Non-prescription medications (i.e., samples, over-the-counter drugs, vitamins, herbals, nutraceuticals and health supplements)

• **Try to use at least two sources of information when possible**
  - Explore discrepancies between the different sources of information

• Recent changes in the regimen are documented such as when the patient last took each medication

• Other important parts of the medication history include:
  - Allergies and associated reactions
  - Name and specialty of prescribers as well as name/location of pharmacy(ies)
# Example Intensive Med List Collection Form

## Patients

- **Pt. Name:**
- **DOB:**
- **Sex:**
- **Age:**
- **Occupation:**
- **Hospital:**
- **Date of Admit:**

## Medication List Collection Form

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<tbody>
<tr>
<td>(Name, Strength, Directions)</td>
<td>(Name, Strength, Directions)</td>
<td>(Name, Strength, Directions)</td>
<td>(Name, Strength, Directions)</td>
<td>(Name as written on Ex-Porta, Strength, Directions)</td>
<td></td>
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</tr>
</tbody>
</table>

## Best Possible Medication History (BPMH)

- **Outpatient Provider:**
- **Provider Phone:**
- **Provider Fax:**

**Catholic Medical Partners**
**Independent Practice Association**

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Best Possible Medication History (BPMH) Cont’d

Patient Interview:

… “Leading the Witness” …

Do NOT lead the witness

"Objection, Your Honor. Counsel is leading the witness."
Best Possible Medication History (BPMH)

Probing Questions to help elicit the BPMH list:

• What medications do you take at home?
• Ask about scheduled medications
  • Which medicines do you take every day, regardless of how you feel?
• Ask about PRN medications
  • Which medicines do you take only sometimes?
  • What symptoms prompt you to take them?
  • How many doses per week do you take?
  • What’s the most often you are allowed to take it?
  • How often do you take something for headaches? Allergies? To help you fall asleep? When you get a cold? For heartburn? For constipation?
• Fill in the gaps for each medication- elicit the dose and time(s) of day the patient takes it, if this information has not already been provided
  • When appropriate, ask about formulation (extended or sustained release forms of medications) and route of administration (by mouth, in both eyes, subcutaneously, etc.)
Best Possible Medication History (BPMH)

Probing Questions for purpose and appropriateness:

• Assessing the purpose of each medication may lead to additional prompts
  • What is each medicine for?
  • What other medications do you take for that?

• Ask about medications for specific conditions that the patient has
  • What medicines do you take for your diabetes, high blood pressure, etc.?

• Ask about medications prescribed by specialists who follow the patient
  • What does your arthritis doctor, cardiologist, etc. prescribe for you?
Best Possible Medication History (BPMH)

Probing Questions to help elicit the BPMH list:

• Ask about non-prescription products
  • Which medicines do you take that don’t require a prescription (Over-the-counter medicines, vitamins, herbals and minerals)?

• Ask about medications that are easy to forget, including those that are not taken orally, may be taken at night, or are used at longer intervals such as weekly or monthly
  • What inhalers, nebulizers, nasal sprays, ointments, creams, eye drops, ear drops, patches, injections or suppositories do you use?
  • How many medications do you take in the evening or at night?
  • How often do you take medicines once a week or once a month?

• Assess recent medication use as well as adherence
  • When did you take the last dose of each of your medicines?
  • Tell me about any problems that you’ve had taking these medicines as prescribed (how often would you say that you miss a dose?)
  • Many patients have difficulty taking their medications exactly as they should every day. In the last week, how many days have you missed a dose of your medication(s)?
Best Possible Medication History (BPMH)

Pearls on investigating and explaining discrepancies:

- Identify the “learner” vs. the ultimate user
- Solicit questions effectively by keeping it simple
  - Use a standard script that includes all key content and questions
  - Improves reliability by gathering the most important information
- Ask patients to “teach back” key information to ensure proper two-way communication and confirm comprehension/understanding
- **IMPORTANT NOTE** – Good Medication Reconciliation takes TIME to collect
  - It can be complex even in basic patients and increases exponentially with the number of providers that the patient sees as well as with the number of medications in a patient’s regimen
  - Expect that this can be relatively labor and time intensive
    - However, taking an accurate pre-visit medication history may be the single most important step to improving medication safety during routine care and especially transitions in care
## Thinking Critically

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Example</th>
<th>Requires Physician Follow Up? (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“One-to-One Match”</strong></td>
<td>Medications ordered for the patient during the episode of care or upon discharge match what the patient was taking prior to admission</td>
<td>Patient takes furosemide 40 mg by mouth twice daily at home, which is ordered upon admission. Patient’s pre-admission dose of simvastatin by mouth every evening is continued during the hospital stay and at discharge</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Intended Discrepancy (i.e., purposeful)</strong></td>
<td>Discrepancies exist but are appropriate based on the patient’s plan of care (e.g., based on information gathered on rounds, based on a review of the physician’s history and physical and progress notes, based on communication/handoffs in preparation for discharge, etc.).</td>
<td>Antibiotics started for infection “As needed” medications ordered for pain/fever Pre-admission doses of patient’s blood pressure medications were changed due to hypotensive episodes Warfarin and aspirin held for a procedure Formulary substitution</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Unintended Discrepancy</strong></td>
<td>Discrepancies exist and require clarification of intent because there is no supporting documentation or explanation based on the patient’s current clinical condition or care plan</td>
<td>The patient takes her blood pressure medication twice daily at home but it’s ordered only once daily in the medical record (hospital). No indication for frequency change and patient’s current blood pressure slightly elevated Insulin started patient is telling you they never took insulin before, no indication noted.</td>
<td>YES</td>
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<tr>
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<td></td>
<td>Physician should be consulted for resolution and resulting changes and/or clarifications documented.</td>
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</tbody>
</table>

Adapted from Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation; Publication # 11(12)-0059
GPRO Reporting Measure – 2016

• Documentation of *Current Medications* in the Medical Record:
  • All visits for patients 18 years of age or older
  • Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources

  • The provider atests to having documented a list of current medications utilizing all immediate resources available at the time of the encounter

  • This list must include all prescriptions, over-the-counter (OTC) products, herbals, vitamins, minerals, dietary (nutritional) supplements
    • AND must contain the medications’ name, dosage, frequency and route of administration

  • This measure should also be reported if the eligible professional documented the patient is not currently taking any medications

Documenting the process and critical thinking
Med Rec – General Process Overview

At each visit for appropriate patients:

Step 1: Identify any recent inpatient stays or specialist visits
Step 2: Take a Best Possible Medication History (BPMH)
Step 3: Compare the BPMH with the current EHR reference list to identify and correct any unintentional discrepancies
Step 4: Document that the medication list in the EHR was updated
Step 5: Communicate applicable changes/updates to the appropriate provider
Step 6: Educate the patient about each current medication that they are to be using including their names (brand and generic), purpose, potential adverse effects, and duration of treatment
  • Highlight and explain stopped, changed or new medications compared with the original reference list and the reasons for those changes
Be aware of “High Risk” Medications

Not an all-inclusive list:

• Blood Thinners – Coumadin; Jantoven (warfarin), Pradaxa (dabigatran), Xarelto (rivaroxaban), Eliquis (apixaban), etc

• Insulins – numerous types, pens and vials, long and rapid acting (i.e., Novolog, Humalog, Lantus, Levemir), extreme caution with U-500, etc

• Methotrexate (Trexall, Rheumatrex)

• Parkinson agents – Sinemet (carbidopa/levodopa), Mirapex (pramipexole), Zelapar (selegiline), Comtan (entacapone)

• Stimulants – Metadate; Concerta; Adderall, Ritalin (methylphenidate), Nuvigil (armodafil), etc

• Transplant agents – Prograf (tacrolimus), Neoral (cyclosporine), Cellcept (mycophenolate), Imuran (azathioprine), etc

• Narcotic agents – Lortab, Norco, Percocet, Morphine, etc

https://www.ismp.org/educational/webinars.asp
http://www.consumermedsafety.org/
High-Alert Med Patient Handouts
Case Example #2 (Coordination of Care)

84 year-old male with CHF and CAD

- Primary provider EHR had at a higher metoprolol tartrate total dose (50 mg twice daily = 100 mg daily) than the patient was originally prescribed by his cardiologist Toprol XL® (metoprolol succinate 50 mg daily)
  - Was taking the dose as re-ordered by PCP
  - Patient went to the bathroom with the assistance of a walker, became lightheaded and passed out

-Required ED visit for a fall due to hypotension/bradycardia-
Case Example #3 (Med Rec Save)

42 year-old, newly diagnosed T2DM patient was discharged from acute care with a metformin prescription that she had filled and picked up

- When reviewing her current therapies at the medication reconciliation interview, the patient stated that she believed her “metformin wasn’t working for her at all”
  - Probing questions resulted in learning that at home the patient was testing her blood sugars periodically and taking her metformin in response to hyperglycemia
    - Patient had become accustomed to sliding scale insulin administered in the hospital in response to hyperglycemia
  - Patient had consumed ~40 tablets of metformin ER 500mg in 3-4 days

- A potentially serious adverse reaction was prevented-
Question #5

How useful did you find today’s presentation on medication reconciliation?

• A. Very useful
• B. Somewhat useful
• C. Neither useful nor not useful
• D. Somewhat not useful
• E. Not useful
Question #6

What did you think of PollEverywhere®?

- A. Fun and interactive!
- B. Distracting from the presentation
- C. Not practical for these webinars
- D. Indifferent to its use
- E. I couldn’t figure it out
CMP Clinical Pharmacy Services Contact

Greg Blette, PharmD
Clinical Pharmacy Consultant
Office: (716) 862-2483
Work Cell: (716) 359-3121
Email: gblette@chsbuffalo.org
Announcements

- Next Lunch & Learn: 7/20/2016
- Topic: "Future Falls Risk-Prevention is Possible"
- Reminders: ACO Notifications, Requests for Tax ID information from PECOS, 2016 MSSP Population Reports
  - Upcoming provider/Office manager meetings:
    - Annual Wellness visit campaign
      - Regional Office manager meetings (July)
    - 9/13/2016 Primary Care Meeting
    - 11/10/2016 Primary and Surgery Sub Specialty

Sheree M Arnold
ACO Clinical Transformation Specialist
sarnold@chsbuffalo.org
(716)862-2453